Healthpoint

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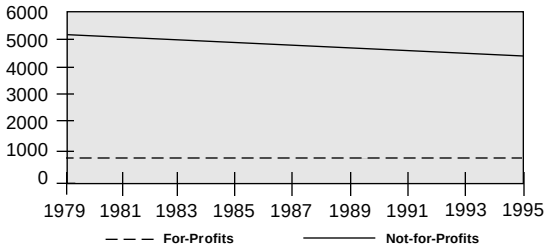
Does hospital ownership matter?

Since Columbia/HCA, the nation's largest for-profit health care corporation, took over Metrowest Medical Center in 1996, the conversion of not-for-profit hospitals to for-profit facilities has provoked strong debate in Massachusetts. The policy debate reached its most vocal level with the proposed sale of Neponset Valley Health System to Columbia/HCA. Public opposition to the acquisition prompted the introduction of legislation to halt future transfers until further review of the social and economic impacts. Laws to regulate the transfer of hospital assets from community boards to for-profit entities are under consideration throughout the country. Rhode Island and New Hampshire have already passed such legislation. This issue of *Healthpoint* provides a context for thinking about hospital conversions, examines the extent of for-profit ownership in Massachusetts, discusses the specific issues surrounding hospital asset transfers, and highlights existing and proposed policies designed to manage the conversion process.

Are We Missing the Forest for the Trees?

Investors seeking profits is only one feature of a hospital industry that has undergone profound change over the past two decades. Fifteen years ago, hospitals controlled the terms of inpatient care, deciding the level of services patients received and being reimbursed their full costs. In 1983, Medicare replaced cost-based payment with a set of prices based on diagnosis, releasing a flood of competitive pressures. Many laws regulating hospitals have been rescinded, giving other payers freedom to arrange independent contracts. Managed care organizations have become major players, negotiating lower hospital rates. Independent physician practices have begun to consolidate, strengthening their leverage in hospital contract negotiations. Many hospitals have entered affiliations, creating competitive advantages through lower unit costs. As a result of all this, many nonprofit hospitals face financial uncertainty.

Figure 1: Number of U.S. Hospitals by Ownership



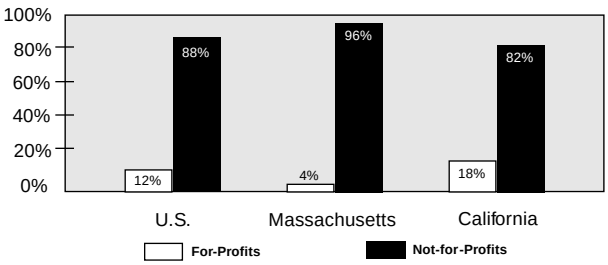
Note: Not-for-profit hospitals include state and local government facilities.
Source: *1996/97 Hospital Statistics*, AHA

These growing competitive pressures blur many of the traditional distinctions between profit and not-for-profit facilities. Profit-oriented practices —reducing and downgrading patient care staffing, eliminating unprofitable services and undertaking marketing and other promotional activities, for example — are reportedly being adopted by non-profits. Competition may also affect hospitals' traditional function of providing indigent care. In today's market, hospitals may be less able to perform this task without exposing themselves to further financial risk. This depends less on whether or not they are profit-making than on the extent and sources of price competition in their market.

What's the Reality in Massachusetts Today?

The perception of widespread hospital conversions does not match the reality. For-profit facilities represent a fraction of all community hospitals in the US.[1] According to the American Hospital Association's latest survey, 15 percent of hospitals were investor-owned in 1995, accounting for 12 percent of hospital beds and 11 percent of admissions (see Figure 1 on page 1). Historically, investor-owned hospitals played a much larger role. In the early 1900s, over half of all hospitals were run by doctors on a for-profit basis (though, admittedly, they looked very different from today's corporations). By the end of WWII, their share had dropped to below 20 percent, and has remained there ever since.

Figure 2: 1995 Share of Hospital Beds by Ownership



Note: Not-for-profit hospitals include state and local government facilities.
Source: *1996/97 Hospital Statistics*, AHA

For-profit hospitals are even less prevalent in Massachusetts. According to AHA data, six percent of the state's hospitals were owned by for-profit companies in 1995, compared with 25 percent in California. Investor-owned facilities in Massachusetts controlled four percent of hospital beds and two percent of admissions (see Figure 2 left).

Despite the small share of for-profit hospitals in Massachusetts, the importance of investor-owned conversions should not be ignored. First, for-profit chains may continue expanding their presence in the State. In 1993 and 1994, two hospitals were bought by for-profit chains. (See Figure 3 below). By 1997, two more hospitals had been converted, with two offers under review. (One of these offers has been rescinded.) Since many of the basic management decisions of for-profits get made by executives who reside outside of the region and are based on the short-run interests of shareholders, further conversions in the state raise concerns about the ability of hospitals to continue meeting their social obligations. The second reason hospital ownership is an important policy issue is that the establishment of a few investor-owned facilities can have an enormous impact on the practice styles of non-profits. For-profits introduce greater competition, forcing all hospitals in the market to adopt "profit-based" management strategies.

Figure 3: For-Profit Hospitals in Massachusetts, 1997

Hospital	Owner	Status
Braintree Hospital	Healthsouth	completed
Fairlawn Rehabilitation Hospital	Healthsouth	completed
New England Rehab. Hosp.	Healthsouth	completed
Whittier Rehabilitation Hospital	Individually owned	completed
JB Thomas (THC-Boston)	Transitional	completed
Hahnemann (Vencor Hospital)	Vencor	completed
Metrowest Medical Center	Columbia/HCA	completed
St. Vincent's Health Care System	Tenet	completed
Boston Regional Medical Center	Doctors' Corp. of America	pending
Neponset Valley Health System	Columbia/HCA	canceled

Note: Rehabilitation facilities included in this table meet the AHA's criterion of average lengths of stay less than 30 days. In addition to for-profit "community" hospitals, the 1997 AHA Guide identifies 13 "non-community" investor-owned facilities in Massachusetts, including ten psychiatric, two substance abuse and one rehabilitation (with an average length of stay longer than 30 days).

What Are the Issues?

There are four broad categories of issues that policy makers should consider when a hospital proposes a change in ownership.

Short-run financial imperatives. In today's competitive market, many hospitals are unable to repay the huge debts accumulated during the expansionary periods of the 1970s and 1980s. A survey by Project Hope of ten converted hospitals around the country reported that several facilities would have been forced to close without the access to capital markets offered by for-profit companies.[2] Hospitals claimed they had no choice but to consider for-profit over nonprofit affiliations because only the former provided debt repayment. An analysis of all hospital conversions between 1988 and 1995 confirmed that, before conversion, the facilities were in relatively poor financial shape.

Long-run economic sustainability. Project Hope's survey reported that several hospitals converted because their boards believed they would be unable to survive as an independent facility given the consolidation and increased managed care penetration in their markets. Hospital administrators claimed that merging with a larger investor-owned chain offered the best opportunity to build networks of providers, increase leverage with third party payers, and exploit efficiencies in scale and scope.

The impact of ownership on efficiency is unresolved. A 1997 Harvard Medical School study found greater shares of administrative costs and higher per-patient costs in for-profits. A 1997 study by the Voluntary Hospital Association (VHA) of six hospital markets in Florida found that purported cost savings in for-profits were achieved through lower patient care staffing. Other studies, however, conclude that for-profits are more efficient than not-for-profits (Ferrier and Valdmanis, 1996).

Quality and access. One concern surrounding conversions is that the profit motive will impel hospitals to lower quality of care. Even when quality remains unaffected, communities fear that converted hospitals will select healthier, more profitable patients, while discouraging the admission of the severely or chronically ill. One way of doing this is by eliminating unprofitable services in such areas as trauma care, mental health and obstetrics.

The evidence on differences in quality and access between for-profits and non-profits is also equivocal. Shortell and Hughes (1988) and Kuhn et al. (1994) found no difference in mortality rates between the two types of institutions. Mann et al. (1995) state anecdotally that more than half of the converted hospitals in Southern California once belonging to a trauma care network downgraded their emergency rooms, no longer designating them trauma centers. A recent study of inpatient psychiatric services (Schlesinger, et al., 1997) found non-profits provided greater access in terms of availability of services and provision of uncompensated care.

Community benefits. In exchange for their tax-exempt status, nonprofit hospitals have assumed the role of providing many of the community benefits of health care, such as the provision of indigent care, unprofitable services, health care research and education, and public health services like immunizations and screenings. Here again, the evidence of whether for-profits provide fewer social goods is inconclusive. Young et al. (1997) and Norton and Staiger (1994) conclude that, when for-profits and not-for-profits are located in the same area, they serve an equal number of uninsured patients. In contrast, other studies found that for-profits provided less free care, research and education than their nonprofit counterparts (Mann et al. [1995], VHA [1997]).

In sum, legislators wishing to protect the community benefits of health care must address the full range of financial and economic realities facing hospitals in today's competitive market. Simply placing a moratorium on future conversions maintains existing inefficiencies in the hospital sector and puts many stand-alone facilities at a competitive disadvantage. On the other hand, policy mak-

ers ought to ensure that when hospitals do convert to for-profit entities, access and quality are not adversely affected by the transfer and all charitable assets remain available for continued public use.

What Should We Be Doing?

State responsibility for approving hospital conversions lies with the Attorney General (AG) and the Department of Public Health (DPH). The AG sees that conversions do not violate antitrust laws and assets continue to fulfill charitable obligations. DPH ensures that community benefits are considered when issuing hospital licenses. Final licensure decision rests with the Public Health Council only after a public hearing gives interested parties the opportunity to voice their concerns.

A wide variety of tools have been used to manage hospital conversions. Guidelines cover such areas as providing for open public discussion and information prior to conversion, securing commitments regarding service levels and community benefits, establishing autonomous control of and reporting on charitable assets, prohibiting financial gain by employees or trustees of a nonprofit entity, and limiting the speed and the extent of for-profit expansion. Policy makers may also consider initiatives that shift some of the burden of free care away from hospitals. Steps in this direction already being taken include expanding health insurance coverage for low income people and using the uncompensated care pool to finance preventive health services among the uninsured.

Not only is it too soon to draw firm conclusions from the data, but such a narrow focus detracts from the larger issue of the impact of increased price competition on all hospitals. This report was intended to provide a framework for thinking about conversions and about public policies to manage future transfers. Competition creates opportunities to realize efficiencies in the provision of health care services, as well as challenges to develop new ways of fulfilling the social obligations. There is no reason why hospital conversions cannot be designed in a way that contributes to both of these aims.

Endnotes

1. For reasons of consistency and availability of data, this issue uses the American Hospital Association's definition of community hospitals: non-federal, short-term general and other specialty facilities. These are acute care hospitals as well as rehabilitation facilities with average lengths of stay less than 30 days.
2. *Healthpoint* strives to highlight information specific to Massachusetts. All of the evidence reviewed in this section, however, is based on studies conducted outside the Commonwealth. The number of for-profit hospitals in Massachusetts is not yet large enough, nor have those that do exist been here long enough, to provide a statistically meaningful basis for analysis.

Further Reading

For the full citations of the references in this article, please visit the Division's web site at http://www.state.ma.us/dhcfp/.

Did you know?

Massachusetts HMO Spending and Utilization, 1995

Spending, Per Member Per Month	Low	Median	High
Total	$ 123.19	$ 145.82	$ 160.31
Non-medical	$ 13.13	$ 20.07	$ 28.00
Medical	$ 106.07	$ 127.52	$ 137.07
Inpatient Facility	$ 22.00	$ 27.22	$ 34.78
Pharmacy	$ 8.23	$ 11.61	$ 16.63
Ambulatory Surgery	$ 3.99	$ 6.37	$ 10.82
Emergency Room	$ 0.50	$ 2.83	$ 4.63
Professional and Other	$ 60.04	$ 74.66	$ 95.16
Utilization, Per 1,000 Members	**Low**	**Median**	**High**
Medical/Surgical Inpatient Days	128	151	229
Ambulatory Surgery Visits	40	63	108
Emgency Room Visits	96	138	276

Source: Massachusetts Division of Health Care Finance and Policy, *HMO Rate Anallysis*, June, 1997. The full report, which includes comparisons of data from 15 HMOs, is available from the Division. To obtain a copy of this report, please call Dorothy Barron at (617) 988-3125 or visit our web site at http://ww.state.ma.us/dhcfp.

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